MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address John B. Payne 313 Westpark Way Eusless, TX 76040	MDR Tracking No.: M4-03-8572-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. P.O. Box 12029 Austin, TX 78711	Date of Injury: Employer's Name: Head Start of Greater Dallas Insurance Carrier's No.: 9900000221298

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/14/02	09/14/02	99214	$10.65	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 07/28/03 states in part, "…This dispute is not ripe for dispute resolution as the requester has not requested reconsideration of the reimbursement. The requester did not request a reconsideration of the $60.35 reimbursement. This carrier requests the Commission dismiss this request for dispute resolution. The requester has not complied with TWCC Rule 133.304(k) which states that 'If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action… ' The requester apparently is not dissatisfied with this carrier's final action as the requester has not requested reconsideration of this charge…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99214 for date of service 09/14/02 denied as "C, YC – Reimbursed per negotiated contract with Health Net Plus (formerly EOS) managed care services, Inc…" Per Rule 413.016(b) the respondent submitted an EOB which shows payment was made in accordance with the negotiated contract provider. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of a request for reconsideration. Additional reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	02/17/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____